Washington State Employee Assistance Program (EAP)
Network of Contracted Provider Application

Type or legibly print application in ink.
Complete application, sign, and attach current copies of the following:
□ *State Professional License*
□ *Resume Including Curriculum*
□ *Copies of Certifications*
□ *Face Sheet of Professional Liability Policy of Certificate*

Applicant Information		
Last Name (include Jr., Sr.)	First Name	Middle
List other name(s) which you have been known by:		
Home Address	City	State, Zip
Mailing Address	City	State, Zip
Home Phone	Work Phone	Cell Phone
Email Address	Web Site Address	Are you a US Citizen? Yes ☐ No ☐
Date of Birth (month/date)	Birthplace (city, state, and country)	What language other than English, do you speak?
Practice Information		
Practice Name	Primary Contact (name & title)	Phone
Mailing Address	City	State, Zip
Billing Address (if different from above)	City	State, Zip
Email Address	Fax	
Office Hours	Is Your Practice ADA Compliant? Yes ☐ No ☐	
National Provider Identifier (NPI)	Check All Locations That You Are Willing To Provide Services To: Ellensburg ☐ Longview ☐ Tri Cities ☐ Vancouver ☐ Wenatchee ☐ Yakima ☐ Other ☐ (indicate location)	
Minority and Women's Business Enterprises (OMWBE) Certification		
Minority and/or Women Owned Business? Yes ☐ No ☐	If **yes**, Certification Number	

Public Employees Insurance Providers – check all providers that you are currently contracted with to provide mental health or chemical dependency issues.		
Aetna Public Employees Plan ☐ Group Health Classic ☐ Group Health Value ☐ Kaiser Permanente Classic ☐ Kaiser Permanente Value ☐ Uniform Medical Plan ☐		
Undergraduate Education		
College/University	Degree	Graduation Date (mm/yyyy)
Address	City	State, Zip
College/University	Degree	Graduation Date (mm/yyyy)
Address	City	State, Zip

Masters Degree Program or Post Graduate Education	
College/University	Program/Degree Received and Graduation Date
Dates Attended	Address
City	State, Zip
College/University	Program/Degree Received and Graduation Date
Dates Attended	Address
City	State, Zip

Certification/Licensure – attach a copy of your certification(s)/license(s)		
Licensing Board	State	Is Certification/License Active? Yes ☐ No ☐
Certification/License Number	Original Issue Date	Expiration Date
Licensing Board	State	Is Certification/License Active? Yes ☐ No ☐
Certification/License Number	Original Issue Date	Expiration Date

Work History – list all work history since completion of professional training. If more space is needed add additional pages.		
Current Practice/Employer	Contact Name	Phone
Address	City	State, Zip
Month & Years Employed in this Position	From (mm/yyyy)	To (mm/yyyy)
Reason for Leaving		
Previous Practice/Employer	Contact Name	Phone
Address	City	State, Zip
Month & Years Employed in this Position	From (mm/yyyy)	To (mm/yyyy)
Reason for Leaving		
Previous Practice/Employer	Contact Name	Phone
Address	City	State, Zip
Month & Years Employed in this Position	From (mm/yyyy)	To (mm/yyyy)
Reason for Leaving		

Gaps in Employment – explain gaps in employment between professional school graduations to present that is not covered on the application.		
From (mm/yyyy)	To (mm/yyyy)	Explanation
From (mm/yyyy)	To (mm/yyyy)	Explanation

Applicant's Employee Relationship with Washington State - If any officer or employee of the Applicant named in any part of the Application is or was an employee of Washington State during the twenty-four (24) months preceding the Application submission date, please provide the following.	
Name	Dates of Employment
State Agency/Institution	Position Held

Name	Dates of Employment	
State Agency/Institution	Position Held	
Professional Liability Insurance - attach a copy of your Face Sheet of Professional Liability Policy of Certificate		
Current Insurance Carrier	Policy Number	Phone
Address	City	State, Zip
Per Claim Amount $	Aggregate Amount $	
Date Begin	Expiration Date	
Peer Reference – list at least three (3) professional references, from your specialty area, (not including relatives) who have worked with you in the past two (2) years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area.		
Name of Reference	Title & Specialty	Phone
Address	City	State, Zip
Relationship		
Name of Reference	Title & Specialty	Phone
Address	City	State, Zip
Relationship		
Name of Reference	Title & Specialty	Phone
Address	City	State, Zip
Relationship		

Professional Affiliations – list membership in all professional societies		
Name of Society	Date Joined	Current Member? Yes ☐ No ☐
Name of Society	Date Joined	Current Member? Yes ☐ No ☐
Name of Society	Date Joined	Current Member? Yes ☐ No ☐

Employee Assistance Education, Experience, and Certification – check all that apply

☐ Active status as a Certified Employee Assistance Professional (CEAP); **or**
☐ Two (2) years of verifiable experience as an internal EAP Counselor, and/or as external EAP Consultant to other organizations.

Training and Experience Types:
Type 1: Management and/or union representation consultation on impact of personal problems, performance issues, appropriate use of constructive confrontation, and role of EAP.
Type 2: Direct care function of EAP practice including assessment/referral, short term counseling, and linkages to treatment and/or community resources.
Type 3: Crisis Intervention including critical incident stress management (CISM) services.
Type 4: Training and experience in organizational dynamics/development, human resource management or industrial social work/psychology.
Type 5: Assessment and identification of drug, alcohol abuse/dependency problems, and appropriate treatment interventions.

On the table below indicate the Type(s) of Training and Experience you have from the list above.

Type	From (mm/yyyy)	To (mm/yyyy)	Your Title	Practice/Employer Name & Address

Knowledge and Work Experience in Assessment/Treatment of Substance Abuse – check all that apply and attach copies of certification(s)

☐ Active status as a Certified Employee Assistance Professional (CEAP) with experience in the assessment/treatment of chemical dependency; **or**
☐ Possess one (1) year experience in a substance abuse treatment facility; **or**
☐ Completed a state level certification to support eligibility for the National Certified Addiction Counselor (NCAC) credential; **or**
☐ Possess International Certified Alcohol and Drug Counselor Certification (ICADC); **or**
☐ Possess a minimum of six (6) units of continuing education (CEU's, PDH's) in chemical dependency assessment/treatment within the last two (2) years.

Certification Type	Certification Number	Expiration Date (mm/dd/yyyy)

Do you have one (1) year of experience in a substance abuse treatment facility? Yes ☐ No ☐ If **yes**, complete the following:		
Treatment Facility	Phone	Your Title
From (mm/yyyy)	To (mm/yyyy)	Hours Per Week
Your Duties		
Treatment Facility	Phone	Your Title
From (mm/yyyy)	To (mm/yyyy)	Hours Per Week
Your Duties		
Treatment Facility	Phone	Your Title
From (mm/yyyy)	To (mm/yyyy)	Hours Per Week
Your Duties		

EAP Network of Contracted Provider Attestation Questions

Please answer all questions. If you answer YES to any of the questions, provide details on a separate sheet and sign and date each sheet. This information may be subject to public disclosure as outlined in Section 3.2, *(MUR) Proprietary information, Confidentiality and Public Disclosure*, of the Request for Qualifications.

Professional Sanctions:

1. Have you ever, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to prelude an investigation or while under investigation relating to professional competence or conduct?	Yes ☐ No ☐
a) License to practice any profession in any jurisdiction?	Yes ☐ No ☐
b) Other professional registration or certification in any jurisdiction?	Yes ☐ No ☐
c) Specialty or subspecialty board certification?	Yes ☐ No ☐
d) Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc?	Yes ☐ No ☐
e) Medicare, Medicaid, FDA, NIH, governmental, national or international regulatory agency or any public program?	Yes ☐ No ☐
f) Professional society membership or fellowship?	Yes ☐ No ☐
g) Participation/membership in a HMO, PPO, IPA, PHO or other entity?	Yes ☐ No ☐
h) Authority to prescribe controlled substances (DEA or other authority)?	Yes ☐ No ☐
2. Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	Yes ☐ No ☐
3. Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	Yes ☐ No ☐
4. Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	Yes ☐ No ☐

Criminal History

1. Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	Yes ☐ No ☐
a) Do you have notice of any such anticipated charges?	Yes ☐ No ☐
b) Are you currently under governmental investigation?	Yes ☐ No ☐

Affirmation of Abilities

1. Do you presently use any drugs illegally?	Yes ☐ No ☐
2. Do you have or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice?	Yes ☐ No ☐

Litigation and Malpractice Coverage History

1. Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	Yes ☐ No ☐
2. Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	Yes ☐ No ☐
3. Are there any such claims being asserted against you now?	Yes ☐ No ☐
4. Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	Yes ☐ No ☐
5. Are any of the privileges that you are providing NOT covered by your current malpractice coverage?	Yes ☐ No ☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate and current. I understand that any misstatements in or omissions from this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Name (print): _____

Provider Signature: _____Credentials:_____ Date: _____

EAP Network of Contracted Provider Authorization and Release of Information

By submitting this authorization and release of information form in conjunction with the EAP Network of Contracted Provider Application and/or the Network of Contracted Provider Attestation, and supporting documentation, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for participation status with the Washington State Department of Personnel Employee Assistance Program (DOP/EAP) indicated on the provider application for initial contracting or re-contracting. I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the DOP/EAP.
2. I further understand and acknowledge that DOP/EAP or other designated agency will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of DOP/EAP as part of the verification and contracting process.
3. I authorize all individuals, institution and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the DOP/EAP or other agency designated in writing, their staffs, and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available to interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigation, and evaluation of my application and qualifications, and I waive all legal claims against any representative of DOP/EAP or its agents who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I am responsible for notifying the DOP/EAP of any changes/challenges to licensure, malpractice claims, criminal convictions, or other disciplinary actions.
7. I attest to the accuracy, currency, and completeness of the information provided. I understand and agree that any misstatement in or omissions from the EAP Network of Contracted Provider Application, EAP Network of Contracted Provider Attestation and attachments hereto shall constitute cause for an application to be rejected as non-responsive, or if a contract has been executed, for termination of the contract.
8. I agree to exhaust all available procedures and remedies as outlined in DOP/EAP rules, regulations, and policies, and/or my contractual agreements with DOP/EAP.
9. I understand that completion and submission of the EAP Network of Contracted Provider Authorization and Release does not automatically grant me membership or participating status with DOP/EAP.
10. I herby further authorize and consent to the release of information and/or reporting by the medical associations, licensing boards, the National Practitioner Data Bank, and other similar organizations regarding any pertinent information which they may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability and the staff and representatives of such organizations for so doing.
11. I further acknowledge that I have read and understand the foregoing EAP Network of Contracted Provider Authorization and Release. A copy of this form shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Name (print): _____

Provider Signature: _____Credentials:_____ Date: _____

Mail this application form, attachments, and requested documentation to:

Department of Personnel
Attn: Contracts Administrator
521 Capitol Way South
P O Box 47500
Olympia, WA 98504-7500